PRESSURE ULCER DRESSING CHANGE

PURPOSE

To remove secretions and dead tissue from the wound.

To decrease infection in wound.

To promote healing.

APPLIES TO

- ❑ Registered Nurses
- ❑ Licensed Practical/Vocational Nurses
- ❑ Therapists
- ❑ Other (Identify): ______________________

EQUIPMENT/SUPPLIES

- Irrigation set or irrigating syringe.
- Gloves. (sterile and non sterile).
- Sterile saline and basin.
- 4 x 4 gauze sponges.
- Cotton swabs.
- Wound measuring device.
- Topical dressing per order.
- Hypoallergenic tape or netting.
- Betadine solution.
- Betadine swabs.
- Plastic bag for waste.

PROCEDURE

1. Gather equipment.
2. Wash hands. Refer to the Hand Washing procedure.
3. Explain procedure to client.
4. Put on gloves and remove old dressing and discard.
5. Note color amount and odor of drainage and presence of necrotic debris.
6. Apply new pair of gloves.
7. Measure wound perimeter with disposable device.
8. Using syringe, irrigate with force to remove necrotic tissue and decrease the presence of bacteria in the wound.
9. Assess for undermining or wound tunneling by inserting sterile swab into the wound. *(tunneling indicates wound extension) Measure length of undermining (tunneling).*
10. Cleanse the wound bed.
11. Note condition of wound bed and surrounding skin. (If necrotic tissue adheres to wound, notify physician or wound care specialist for debridement).
12. Apply topical dressing (as appropriate for wound and as ordered by physician.

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
   a. Date and time of procedure.
   b. Specific treatment.
   c. Location, size of ulcer.
   d. Color and appearance of wound bed.
   e. Amount color and consistency of drainage.
   f. Condition of surrounding tissue.
   g. Changes in general condition - complaints of pain, elevated temperature.
   h. Physician notification.
   i. Preventive measures taken.
   j. Teaching done.
   k. Client response.

RELATED PROCEDURES

None.